

Michigan Maternal-Infant Health Program Prenatal Risk Factor Screening

1

BASICS/DEMOGRAPHICS

0 SCREENING DATE			
<input type="text"/>	<input type="text"/>	<input type="text"/>	↓
MM	DD	YY	
1.0 IDENTIFICATION			
1.0A NAME			
FIRST	<input type="text"/>		
MID	<input type="text"/>		
LAST	<input type="text"/>		
1.0B MEDICAID ID#			
<input type="text"/>			↓
1.0C SOCIAL SECURITY#			
<input type="text"/>	-	<input type="text"/>	-
<input type="text"/>			↓

1.1 What is your date of birth?			
<input type="text"/>	<input type="text"/>	<input type="text"/>	↓
MM	DD	YY	
<input type="checkbox"/>	REFUSED		
<input type="checkbox"/>	SNAG		
1.2 What do you identify as your race/ethnic background? (Check all that apply)			
<input type="checkbox"/>	Asian		
<input type="checkbox"/>	American Indian or Alaska Native		
<input type="checkbox"/>	Black or African American		
<input type="checkbox"/>	Hispanic/Latino		
<input type="checkbox"/>	Native Hawaiian or other Pacific Islander		
<input type="checkbox"/>	White/Caucasian		
<input type="checkbox"/>	REFUSED		
<input type="checkbox"/>	SNAG		
			➔ 1.3

1.3 How many grades of school have you completed?	
<input type="text"/>	grades completed
Junior high/middle school = 8 High school diploma/GED = 12 Associate's degree = 14 Bachelor's degree = 16	
<input type="checkbox"/>	REFUSED
<input type="checkbox"/>	SNAG
↓	

1.4A Do you currently work outside the home?	
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
↓	
↓ 1.5	

1.4B How many hours do you work in a typical week?	
<input type="text"/>	hours
↓	

1.5 Are you currently attending school?	
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
↓	

1.6 Are you currently married or unmarried?	
<input type="checkbox"/>	Married
<input type="checkbox"/>	Unmarried
<input type="checkbox"/>	REFUSED
<input type="checkbox"/>	SNAG
➔ 2.1A	

2.1A When was your last menstrual period?

<input type="text"/>	<input type="text"/>	<input type="text"/>
MM	DD	YY

↓ 2.2A

DON'T KNOW

REFUSED

SNAG

**2.1B When is your baby due?**

<input type="text"/>	<input type="text"/>	<input type="text"/>
MM	DD	YY

DON'T KNOW

REFUSED

SNAG

**2.2A Thinking back to just before you got pregnant with this baby, how did you feel about becoming pregnant? Did you:**

Want to be pregnant sooner

↓ 2.3

Want to be pregnant later



Want to be pregnant then

↓ 2.3

Not want to be pregnant then or at any time in the future



DON'T KNOW

↓ 2.3

REFUSED

SNAG

2.2B At the time you became pregnant, were you using any birth control method?

Yes

No

DON'T KNOW

REFUSED

SNAG

**2.3 What was your weight just before you became pregnant this time?**

<input type="text"/>	<input type="text"/>	<input type="text"/>
Pounds		

DON'T KNOW

REFUSED

SNAG

**2.4 What is your height without shoes?**

<input type="text"/>	Feet	<input type="text"/>	Inches
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REFUSED

SNAG

➡ 2.5A

2.5A Including this pregnancy, how many times have you been pregnant? (Count any abortions, miscarriages or stillbirths)

1 TIME (FIRST PREGNANCY)

⇒ 2.7

 TIMES

REFUSED

⇒ 2.7

SNAG

2.5B When did your last pregnancy end? (date of last delivery, abortion, miscarriage or stillbirth)

<input type="text"/>	<input type="text"/>
MM	YY

(Approximate if necessary)



REFUSED

SNAG

2.6 Did any of your previous pregnancies result in:

YES NO

2.6A Miscarriage in the 4th month of pregnancy or later?**2.6B** Stillbirth?**2.6C** Baby weighing less than 5.5 pounds at birth?**2.6D** Baby born more than 3 weeks early (or did anyone tell you that your baby was premature/preterm?)**2.6E** Baby that stayed in the hospital after you went home?

REFUSED

SNAG



2.7 Have you ever been treated for or told that you have:

2.7A High blood pressure (hypertension)?

<input type="checkbox"/>	No	<div>↓ 2.7B</div> <hr/> <div>➡</div>
<input type="checkbox"/>	Yes	

2.7A.1 When did you last see a health care provider about this problem?

MONTH:	<input type="text"/>	YEAR:	<input type="text"/>	↓
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2.7A.2 Do you have another visit scheduled?

<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	

2.7A.3 Have you been in the hospital or ER for this problem in the last six months?

<input type="checkbox"/>	Yes	← 2.7B
<input type="checkbox"/>	No	

2.7B Anemia or sickle cell disease?

<input type="checkbox"/>	No	<div>↓ 2.7C</div> <hr/> <div>➡</div>
<input type="checkbox"/>	Yes	

2.7B.1 Have you ever had a blood transfusion for this problem?

<input type="checkbox"/>	Yes	LAST DATE:	<input type="text"/>	↓
<input type="checkbox"/>	No			

2.7B.2 When did you last see a health care provider about this problem?

MONTH:	<input type="text"/>	YEAR:	<input type="text"/>	↓
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2.7B.3 Do you have another visit scheduled?

<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	

2.7B.4 Have you been in the hospital or ER for this problem in the last six months?

<input type="checkbox"/>	Yes	← 2.7C
<input type="checkbox"/>	No	

2.7C Diabetes or high blood sugar?

<input type="checkbox"/>	No	<div>⇒ 2.7D</div> <hr/> <div>➡</div>
<input type="checkbox"/>	Yes	

2.7C.1 Is it Insulin dependent?

<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	

2.7C.2 When did you last see a health care provider about this problem?

MONTH:	<input type="text"/>	YEAR:	<input type="text"/>	↓
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2.7C.3 Do you have another visit scheduled?

<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	

2.7C.4 Have you been in the hospital or ER for this problem in the last six months?

<input type="checkbox"/>	Yes	➡ 2.7D
<input type="checkbox"/>	No	

2.7D	Asthma?	
	No	↓ 2.7E
	Yes	➡

2.7D.1	When did you last see a health care provider about this problem?	
MONTH:	<input type="text"/>	YEAR: <input type="text"/> ↓
2.7D.2	Do you have another visit scheduled?	
	Yes	↓
	No	
2.7D.3	Have you been in the hospital or ER for this problem in the last six months?	
	Yes	← 2.7E
	No	

2.7E	Problems with your heart, kidneys, or lungs?	
	No	↓ 2.7F
	Yes	➡

2.7E.1	When did you last see a health care provider about this problem?	
MONTH:	<input type="text"/>	YEAR: <input type="text"/> ↓
2.7E.2	Do you have another visit scheduled?	
	Yes	↓
	No	
2.7E.3	Have you been in the hospital or ER for this problem in the last six months?	
	Yes	← 2.7F
	No	

2.7F	Problems with bleeding?	
	No	↓ 2.7G
	Yes	➡

2.7F.1	When did you last see a health care provider about this problem?	
MONTH:	<input type="text"/>	YEAR: <input type="text"/> ↓
2.7F.2	Do you have another visit scheduled?	
	Yes	↓
	No	
2.7F.3	Have you been in the hospital or ER for this problem in the last six months?	
	Yes	← 2.7G
	No	

2.7G	Recurring vaginal infections?	
	No	⇒ 2.7H
	Yes	➡

2.7G.1	When did you last see a health care provider about this problem?	
MONTH:	<input type="text"/>	YEAR: <input type="text"/> ↓
2.7G.2	Do you have another visit scheduled?	
	Yes	↓
	No	
2.7G.3	Have you been in the hospital or ER for this problem in the last six months?	
	Yes	➡ 2.7H
	No	

2.7H	A sexually transmitted infection?	
	No	↓ 2.7I
	Yes	→

2.7H.1	When did you last see a health care provider about this problem?	
MONTH:		YEAR: ↓
2.7H.2	Do you have another visit scheduled?	
	Yes	↓
	No	
2.7H.3	Have you been in the hospital or ER for this problem in the last six months?	
	Yes	← 2.7I
	No	

2.7I	Other problems that you see a doctor for?	
	No	↓ 2.8
	Yes	→

2.7I.1	When did you last see a health care provider about this problem?	
MONTH:		YEAR: ↓
2.7I.2	Do you have another visit scheduled?	
	Yes	↓
	No	
2.7I.3	Have you been in the hospital or ER for this problem in the last six months?	
	Yes	← 2.8A
	No	
	REFUSED	
	SNAG	

2.8A	Are you now taking any prescription drugs?	
	Yes	→
	No	↓ 2.9A
	REFUSED	
	SNAG	

2.8B	Which prescription drugs are you taking?	
		← 2.9A

2.9A	How long has it been since you had a dental exam and cleaning?	
	Within the past year	⇒ 3.1
	Within the past 2 years	→ 2.9B
	Within the past 5 years	
	More than 5 years ago	
	Don't know/not sure	
	Never	
	REFUSED	
	SNAG	

2.9B	In the past year, have you noticed any problems with your teeth or gums such as bad breath that won't go away, loose or sensitive teeth, or gums that are red, swollen, tender, or bleeding?	
	Yes	→ 3.1
	No	
	SNAG	

3.1 When you have a health issue or problem, where do you usually go for care?

<input type="checkbox"/>	Doctor's office	↓
<input type="checkbox"/>	Public health clinic	
<input type="checkbox"/>	Readicare facility	
<input type="checkbox"/>	Hospital	
<input type="checkbox"/>	Emergency room	
<input type="checkbox"/>	Other _____	
<input type="checkbox"/>	Nowhere	
<input type="checkbox"/>	REFUSED	
<input type="checkbox"/>	SNAG	

3.2 How many months' pregnant were you when you had your first visit for prenatal care? Do not count a visit that was only for a pregnancy test or only for WIC.

<input type="text"/>	months	↓
<input type="checkbox"/>	I haven't gone for prenatal care	
<input type="checkbox"/>	REFUSED	
<input type="checkbox"/>	SNAG	

3.3 Have you had any trouble getting the prenatal care you want or need?

<input type="checkbox"/>	Yes	➡ 3.4
<input type="checkbox"/>	No	
<input type="checkbox"/>	REFUSED	
<input type="checkbox"/>	SNAG	

3.4 Here is a list of problems some women can have getting prenatal care. For each item, please let us know if it has been true for you at any time during this pregnancy [READ LIST]

<input type="checkbox"/>	I couldn't get an appointment when I wanted one	➡ 4.1
<input type="checkbox"/>	I couldn't find a doctor or clinic that accepted Medicaid	
<input type="checkbox"/>	It is hard to communicate with the doctor or clinic staff	
<input type="checkbox"/>	It is hard to understand the information the doctor or clinic give to me	
<input type="checkbox"/>	I haven't had enough money or insurance to pay for my visits	
<input type="checkbox"/>	I haven't had my Medicaid card or Guarantee of Payment letter	
<input type="checkbox"/>	I've had no way to get to the clinic or doctor's office	
<input type="checkbox"/>	I couldn't take time off from work	
<input type="checkbox"/>	I've had no one to take care of my children	
<input type="checkbox"/>	I have had too many other things going on in my life	
<input type="checkbox"/>	I didn't want anyone to know I was pregnant	
<input type="checkbox"/>	Other. Please tell us: _____	
<input type="checkbox"/>	REFUSED	
<input type="checkbox"/>	SNAG	

4.1 Which of the following statements would you say best describes your cigarette smoking? Would you say:

<input type="checkbox"/>	I smoke regularly now – about the same amount as before finding out I was pregnant	↓
<input type="checkbox"/>	I smoke regularly now, but I've cut down since I found out I was pregnant	
<input type="checkbox"/>	I smoke every once in a while	
<input type="checkbox"/>	I have quit smoking since finding out I was pregnant	
<input type="checkbox"/>	I wasn't smoking around the time I found out I was pregnant, and I don't currently smoke cigarettes.	⇒ 5.1
<input type="checkbox"/>	REFUSED	↓
<input type="checkbox"/>	SNAG	

4.2 How many cigarettes do you smoke on an average day now?

<input type="checkbox"/>	1-1/2 or more packs	→
<input type="checkbox"/>	1 to 1-1/2 packs	
<input type="checkbox"/>	1/2 to 1 pack	
<input type="checkbox"/>	6 to 10 cigarettes	
<input type="checkbox"/>	1 to 5 cigarettes	⇒ 4.4A
<input type="checkbox"/>	Less than 1 cigarette	
<input type="checkbox"/>	REFUSED	→
<input type="checkbox"/>	@ SNAG	

4.3A How soon after you wake up do you smoke your first cigarette?

<input type="checkbox"/>	Within 5 minutes	↓
<input type="checkbox"/>	6-30 minutes	
<input type="checkbox"/>	31 or more minutes	

4.3B Do you find it difficult to stop smoking in non-smoking areas?

<input type="checkbox"/>	No	↓
<input type="checkbox"/>	Yes	

4.3C Which cigarette would you MOST hate to give up?

<input type="checkbox"/>	The first cigarette in the morning	↓
<input type="checkbox"/>	All others	

4.3D Do you smoke MORE FREQUENTLY in the first hours after waking than the rest of the day?

<input type="checkbox"/>	No	↓
<input type="checkbox"/>	Yes	

4.3E Do you smoke if you are so ill that you are in bed most of the day?

<input type="checkbox"/>	No	↓
<input type="checkbox"/>	Yes	

4.4A Have you seriously thought about quitting smoking during this pregnancy?

<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	
		⇒ 5.1

4.4B Have you tried to quit smoking in the last 30 days?

<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	
		⇒ 5.1

4.4C Have you made any changes or gotten any supports to make it easier for you to not smoke?

<input type="checkbox"/>	Yes	⇒ 5.1
<input type="checkbox"/>	No	

5.1 Which of the following statements would you say best describes your alcohol consumption, INCLUDING beer and wine coolers? Would you say:

<input type="checkbox"/>	I drink alcohol regularly now – about the same amount as before finding out I was pregnant	↓
<input type="checkbox"/>	I drink alcohol regularly now, but I've cut down since I found out I was pregnant	
<input type="checkbox"/>	I drink alcohol every once in a while
<input type="checkbox"/>	I have quit drinking alcohol since finding out I was pregnant	⇒ 5.3A
<input type="checkbox"/>	I wasn't drinking alcohol around the time I found out I was pregnant, and I don't currently drink.	⇒ 6.1
<input type="checkbox"/>	REFUSED	↓
<input type="checkbox"/>	SNAG

5.2 Approximately how many alcoholic drinks do you have in an average week?

<input type="checkbox"/>	14 drinks or more a week	➡
<input type="checkbox"/>	7 to 13 drinks a week	
<input type="checkbox"/>	4 to 6 drinks a week	
<input type="checkbox"/>	1 to 3 drinks a week	
<input type="checkbox"/>	Less than 1 drink a week	
<input type="checkbox"/>	REFUSED	
<input type="checkbox"/>	SNAG	

5.3A How many drinks does it take to make you feel high?

<input type="checkbox"/>	1	↓
<input type="checkbox"/>	2	
<input type="checkbox"/>	3 or more	

5.3B Have people annoyed you by criticizing your drinking?

<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	

5.3C Have you ever felt you ought to cut down on your drinking?

<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	

5.3D Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	

5.4A Have you seriously thought about quitting all alcohol during this pregnancy?

<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	
		⇒ 6.1

5.4B Have you tried to quit drinking alcohol in the last 30 days?

<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	
		⇒ 6.1

5.4C Have you made any changes or gotten any supports to make it easier for you to not drink alcohol?

<input type="checkbox"/>	Yes	➡ 6.1
<input type="checkbox"/>	No	

6.1	Does your partner or anyone in your household use street drugs?	
<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	
<input type="checkbox"/>	REFUSED	
<input type="checkbox"/>	SNAG	
6.2A	In the month before you knew you were pregnant, did you use any street drugs, diet pills, or drugs not prescribed by a physician?	
<input type="checkbox"/>	Yes	➡ 6.2B
<input type="checkbox"/>	No	⇒ 7.1
<input type="checkbox"/>	REFUSED	
<input type="checkbox"/>	SNAG	

6.2B	What did you use? (check all that apply) [OPEN ENDED, PROMPT FOR OTHERS]	
<input type="checkbox"/>	Marijuana	↓
<input type="checkbox"/>	PCP	
<input type="checkbox"/>	Crack	
<input type="checkbox"/>	Cocaine	
<input type="checkbox"/>	Heroin	
<input type="checkbox"/>	Uppers/Crank/Meth/Speed	
<input type="checkbox"/>	Downers	
<input type="checkbox"/>	LSD	
<input type="checkbox"/>	Diet Pills	
<input type="checkbox"/>	Prescription drugs not prescribed for you	
<input type="checkbox"/>	Other:	
6.3A	Have you seriously thought about quitting using drugs during this pregnancy?	
<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	⇒ 7.1
6.3B	Have you tried to quit using drugs since you became pregnant?	
<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	⇒ 7.1
6.3C	Have you made any changes or gotten any supports to make it easier for you to not use drugs?	
<input type="checkbox"/>	Yes	⇒ 7.1
<input type="checkbox"/>	No	

7.1	In the last month, how often have you felt nervous and stressed?	
<input type="checkbox"/>	Never	⇒ 8.1 ↓
<input type="checkbox"/>	Almost Never	
<input type="checkbox"/>	Sometimes	
<input type="checkbox"/>	Fairly Often	
<input type="checkbox"/>	Very Often	
<input type="checkbox"/>	REFUSED	
<input type="checkbox"/>	SNAG	
7.2	During pregnancy, pressures and hassles of everyday life can become even harder to cope with. In the last month, have you felt like you were struggling to cope with:	
		YES NO
Problems with money?	<input type="checkbox"/>	<input type="checkbox"/>
Problems with a personal relationship?	<input type="checkbox"/>	<input type="checkbox"/>
Demands of family or children?	<input type="checkbox"/>	<input type="checkbox"/>
Demands of work or school?	<input type="checkbox"/>	<input type="checkbox"/>

7.3A	In the last month, how often have you felt that you were unable to control the important things in your life?	
<input type="checkbox"/>	Never	↓
<input type="checkbox"/>	Almost never	
<input type="checkbox"/>	Sometimes	
<input type="checkbox"/>	Fairly often	
<input type="checkbox"/>	Very often	
7.3B	In the last month, how often have you felt confident about your ability to handle your personal problems?	
<input type="checkbox"/>	Never	↓
<input type="checkbox"/>	Almost never	
<input type="checkbox"/>	Sometimes	
<input type="checkbox"/>	Fairly often	
<input type="checkbox"/>	Very often	
7.3C	In the last month, how often have you felt that things were going your way?	
<input type="checkbox"/>	Never	↓
<input type="checkbox"/>	Almost never	
<input type="checkbox"/>	Sometimes	
<input type="checkbox"/>	Fairly often	
<input type="checkbox"/>	Very often	
7.3D	In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	
<input type="checkbox"/>	Never	⇒ 8.1
<input type="checkbox"/>	Almost never	
<input type="checkbox"/>	Sometimes	
<input type="checkbox"/>	Fairly often	
<input type="checkbox"/>	Very often	

8.1 Over the past 2 weeks, how often have you felt down, depressed, or hopeless?

<input type="checkbox"/>	Not at all
<input type="checkbox"/>	★ Several days
<input type="checkbox"/>	★ More than half the days
<input type="checkbox"/>	★ Nearly every day
<input type="checkbox"/>	REFUSED
<input type="checkbox"/>	SNAG

**8.2 Over the past 2 weeks, how often have you felt little interest or pleasure in doing things?**

<input type="checkbox"/>	Not at all
<input type="checkbox"/>	★ Several days
<input type="checkbox"/>	★ More than half the days
<input type="checkbox"/>	★ Nearly every day
<input type="checkbox"/>	REFUSED
<input type="checkbox"/>	SNAG

IF RACE IS
BLACK ↓ 8.3

OTHERWISE
⇒ 8.4

8.3 Over the past 2 weeks, how often have you had 'nerves' or felt angry, blue, or out of sorts?

<input type="checkbox"/>	Not at all
<input type="checkbox"/>	★ Several days
<input type="checkbox"/>	★ More than half the days
<input type="checkbox"/>	★ Nearly every day
<input type="checkbox"/>	REFUSED
<input type="checkbox"/>	SNAG

**8.4 Do you have a history of depression, "baby blues" or other mental health issues?**

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	REFUSED
<input type="checkbox"/>	SNAG

IF ONE OR MORE ANSWERS TO 8.1 – 8.3 ARE MARKED ★, CONTINUE TO 8.5.

OTHERWISE, SKIP TO 9.1

QUESTIONS 8.4 – 8.13: DEPRESSION FOLLOW UP SCREENING

I'd like to ask you some follow up questions about how you're feeling. I'm going to read you some statements and responses. For each statement, please let me know which response is closest to how you've been in the past 7 days.

8.5	I have been able to laugh and see the funny side of things
<input type="checkbox"/>	As much as I always could
<input type="checkbox"/>	Not quite so much now
<input type="checkbox"/>	Definitely not so much now
<input type="checkbox"/>	Not at all
8.6	I have looked forward with enjoyment to things
<input type="checkbox"/>	As much as I ever did
<input type="checkbox"/>	Rather less than I used to
<input type="checkbox"/>	Definitely less than I used to
<input type="checkbox"/>	Hardly at all
8.7	I have blamed myself unnecessarily when things went wrong
<input type="checkbox"/>	Yes, most of the time
<input type="checkbox"/>	Yes, some of the time
<input type="checkbox"/>	Not very often
<input type="checkbox"/>	No, never
8.8	I have been anxious or worried for no good reason
<input type="checkbox"/>	No, not at all
<input type="checkbox"/>	Hardly ever
<input type="checkbox"/>	Yes, sometimes
<input type="checkbox"/>	Yes, very often
8.9	I have felt scared or panicky for no very good reason
<input type="checkbox"/>	Yes, quite a lot
<input type="checkbox"/>	Yes, sometimes
<input type="checkbox"/>	No, not much
<input type="checkbox"/>	No, not at all

8.10	Things have been getting on top of me
<input type="checkbox"/>	Yes, most of the time I haven't been able to cope at all
<input type="checkbox"/>	Yes, sometimes I haven't been coping as well as usual
<input type="checkbox"/>	No, most of the time I have coped quite well
<input type="checkbox"/>	No, I have been coping as well as ever
8.11	I have been so unhappy that I have had difficulty sleeping
<input type="checkbox"/>	Yes, most of the time
<input type="checkbox"/>	Yes, sometimes
<input type="checkbox"/>	Not very often
<input type="checkbox"/>	No, not at all
8.12	I have felt sad or miserable
<input type="checkbox"/>	Yes, most of the time
<input type="checkbox"/>	Yes, quite often
<input type="checkbox"/>	Not very often
<input type="checkbox"/>	No, not at all
8.13	I have been so unhappy that I have been crying
<input type="checkbox"/>	Yes, most of the time
<input type="checkbox"/>	Yes, quite often
<input type="checkbox"/>	Only occasionally
<input type="checkbox"/>	No, never
8.14	The thought of harming myself has occurred to me
<input type="checkbox"/>	Yes, quite often
<input type="checkbox"/>	Sometimes
<input type="checkbox"/>	Hardly ever
<input type="checkbox"/>	Never

9.1	Would you describe the father of this baby as:	
<input type="checkbox"/>	Involved in my pregnancy and supportive of me	↓
<input type="checkbox"/>	Involved but not supportive of me	
<input type="checkbox"/>	Aware that I'm pregnant but not involved	
<input type="checkbox"/>	Not aware that I'm pregnant	
<input type="checkbox"/>	REFUSED	
<input type="checkbox"/>	SNAG	
9.2A	Is there someone in your life who you can count on to help you during this pregnancy and with your new baby?	
<input type="checkbox"/>	Yes	➡
<input type="checkbox"/>	No	⇒ 10.1

9.2B	Who do you count on for support? (check all that apply)	
<input type="checkbox"/>	Partner and/or the baby's father	➡ 10.1
<input type="checkbox"/>	Parent(s)	
<input type="checkbox"/>	Other child or children	
<input type="checkbox"/>	Other relative(s)	
<input type="checkbox"/>	Friend(s)/Neighbor(s)	
<input type="checkbox"/>	Clergy and/or people at my place of worship	
<input type="checkbox"/>	Other: _____	

10.1	Do you feel safe in your present relationship?	
	I am not in a relationship right now	↓
	Yes	
	No	
10.2A	Within the last year, have you been hit, kicked, slapped, or otherwise physically hurt by someone?	
	Yes	↓
	No	⇒ 10.4

10.2B	By whom? (Check all that apply)	
	Current partner	↓
	Ex-partner	
	Stranger	
	Others	
	Specify: _____	
10.2C	How many times has this happened?	
	_____ times	↓
10.3A	Since you have been pregnant, have you been hit, slapped, kicked or otherwise physically hurt by someone?	
	Yes	↓
	No	⇒ 10.4
10.3B	By whom? (Check all that apply)	
	Current partner	↓
	Ex-partner	
	Stranger	
	Others	
	Specify: _____	
10.3C	How many times has this happened?	
	_____ times	↓
10.3D	What part or parts of your body were hurt?	
	Limbs	➡ 10.3E
	Torso	
	Head	

10.3E	How did this person hurt you? (Score the most severe incident to the following scale):	
	Threats of abuse, including use of a weapon	↓
	Slapping, pushing; no injuries and/or lasting pain	
	Punching, kicking, bruises, cuts and/or continuing pain	
	Beaten up, severe contusions, burns, broken bones	
	Head, internal, and/or permanent injury	
	Use of weapon, wound from weapon	
10.4	Have you ever been emotionally or physically abused by your partner or someone important to you?	
	Yes	↓
	No	
10.5A	Within the past year, has anyone forced you to have sexual activities?	
	Yes	↓
	No	↓ 10.6
10.5B	Who was it?	
	Current partner	↓
	Ex-partner	
	Stranger	
	Others	
	Specify: _____	
10.5C	How many times has this happened?	
	_____ times	↓
10.6	Are you afraid of your partner or anyone you listed above?	
	Yes	➡ 11.1A
	No	

11.1A	In the last 12 months, did you (or other adults in your household) ever cut the size of your meals or skip meals because there wasn't enough money for food?	
<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	↓ 11.2
11.1B	How often did this happen?	
<input type="checkbox"/>	Almost every month	↓
<input type="checkbox"/>	Some months but not every month	
<input type="checkbox"/>	In only 1 or 2 months	
11.2	How many times have you moved in the past 12 months?	
<input type="checkbox"/>	0	↓
<input type="checkbox"/>	1	
<input type="checkbox"/>	2	
<input type="checkbox"/>	3	
<input type="checkbox"/>	4 or more	
11.3A	Do you currently have any concerns or worries about your housing situation?	
<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	⇒ 11.4

11.4	How often do you have access to a telephone to make and receive calls where you live?	
<input type="checkbox"/>	Always	↓ 12.1
<input type="checkbox"/>	Sometimes	
<input type="checkbox"/>	Never	

12	BREASTFEEDING
12.1	Which of the following best describes your thoughts on breastfeeding your new baby?
<input type="checkbox"/>	I know I will breastfeed
<input type="checkbox"/>	I think I might breastfeed
<input type="checkbox"/>	I know I will not breastfeed
<input type="checkbox"/>	I don't know what to do about breastfeeding
<input type="checkbox"/>	REFUSED
<input type="checkbox"/>	SNAG

END

11.3B	What are your concerns or worries about housing? (check all that apply) [OPEN ENDED]	
Instability		
<input type="checkbox"/>	No place to live, no regular night time residence, or live in a shelter.	➡ 11.4
<input type="checkbox"/>	Eviction or being forced to move out.	
<input type="checkbox"/>	Affordability of current house or apartment	
<input type="checkbox"/>	Strained relations with others in household	
Adequacy		
<input type="checkbox"/>	House or apartment is too crowded.	➡ 11.4
<input type="checkbox"/>	Lack of continuous functioning basic utility service (e.g., heat, electricity)	
Safety		
<input type="checkbox"/>	Safety of house/apartment	➡ 11.4
<input type="checkbox"/>	Safety of neighborhood	